12 Month Old AHCCCS EPSDT Tracking Form

Date: | Last Name | First Name | AHCCCS ID#: | Age:

Primary Care Provider Name and Office Phone Number | Contractor: | DOB:

Accompanied by: | Allergies:

Birth Wt: | Weight: | Percentile: | Length: | Percentile: | Head Circ: | Percentile:

HISTORY:

Temp: _____
Pulse: _____
Resp: _____

Parental Comments/Concerns:

Dental Screen: Daily tooth brushing? Yes _____ No _____ Education re: white spots on teeth given? Yes _____ No ___

Nutritional Screen: Breast Feeding: _____ Formula (type): _____ Supplements: _____ Solids: _____

Developmental Screen: Age Appropriate? (e.g., cruises, may take a few steps alone, precise pincer grasp) Yes ___ No ___

If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:	LABS ORDERED:
1. Skin/Hair/Nails				Tuberculin Test
2. Ear/Hearing				Yes _____ No _____
3. Eyes/Vision (red reflex)				**(perform if at risk)**
4. Mouth/Throat/Teeth				
5. Nose/Head/Neck				**SCREENINGS:**
6. Heart				Blood Lead Test
7. Lungs				Yes _____ No _____
8. Abdomen				**(perform at 12 mo of age)**
9. Genitourinary				
10. Extremities				**ADDITIONAL LABS:**
11. Spine (scoliosis)				**Specify:**
12. Neurological				

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** ___ **No** ___ **Delayed?** _____ **Deferred?** _____

Given today? **Hep B** _____ **Hib** _____ **IPV** _____ **MMR** _____ **Varicella** _____

PCV _____ **Influenza** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Sleep practices
- Drowning prevention
- Injury prevention /911
- Car seat/mobility
- Passive smoke
- Nutrition/Self feeding
- Wean from bottle/cup use
- Discipline/praise
- Postpartum adjustment
- Parenting practices
- Family involvement
- Interaction with parents/reading
- Next appt./transportation needed?

REFERRALS: **CRS** ____ **WIC** ____ **DDD** ____ **ALTCS** ____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): | Clinician Signature: | See Additional/Supervisory Note?

Revised January 1, 2004